STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

Healthcare Quality And Safety Branch

August 15, 2019

Lucille Janatka, Administrator
Midstate Medical Center
435 Lewis Avenue
Meriden, CT 06450

Dear Ms. Janatka:

An unannounced visit was made to Midstate Medical Center on July 1, 2019 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, and a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice.

The plan of correction is to be submitted to the Department by August 29, 2019.

The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by August 29, 2019 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

An phone conference has been scheduled for September 11, 2019 at 10:00AM in the Facility Licensing and Investigations

DATE(S) OF VISIT: July 1, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting. Please be prepared to discuss those violations identified with an asterisk.

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Susan Newton, RN, BS
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SHN:mb

Complaint #25708

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6).

DATE(S) OF VISIT: July 1, 2019

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1. *Based on observation, clinical record review, review of hospital policy, review of hospital documentation and staff interviews for 1 of 2 sampled patients (Patient #1) reviewed for self-harm behaviors (inserted foreign body in urethra and swallowed a battery), the facility failed to ensure the patient was supervised and/or continuous observation was maintained and/or failed to ensure the environment was free of hazards. The findings include:
   a. Patient #1's diagnoses included schizophrenia, bipolar disorder, PICA (eating disorder) and self-mutilating behaviors.
      Patient # 1 was admitted to the hospital on 5/16/19 for complaints of pain in the urethra after inserting a food item into the urethra. The History and Physical (H&P) dated 5/16/19 at 2:34 PM identified the patient stated that "he/she stuck a pen cartridge in his/her urethra." The H&P further identified the patient was placed with a one to one sitter and would be evaluated by urology. Review of the surgical report dated 5/16/19 identified the patient underwent a cystoscopic transurethral retrieval of celery.
      i. Physician orders dated 5/16/19 at 3:22 PM directed continuous observation/sitter (one staff member and one security staff observing the patient). Physician orders dated 5/16/19 at 4:28 PM directed no items to be left in room, no utensils, paper products only, visual attention at all times.
      Review of the patient treatment plan dated 5/16/19 identified a history of self-mutilating behaviors of inserting/ingesting foreign objects. Interventions included one to one and security present at all times, remove all objects from room, remote control to be with staff or outside of room, hands remain above blankets, and visualize patient while in bathroom.
      Review of Patient safety checks dated 5/17/19 at 7:00 AM identified Patient # 1 reported he/she inserted a needle cap into his/her urethra at 9:00 PM while in the bathroom.
      A physician progress note dated 5/17/19 at 1:40 PM identified that overnight, despite being on a one to one with security present, the patient inserted a needle cap into the urethra. The patient went to the Operating Room (OR) on 5/16/19 for foreign body removal and the patient went back to the OR for a second cystoscopy on 5/17/19 for removal of the needle cap. The note further identified there was significant swelling of the urethra, a Foley was placed and the patient was started on antibiotic therapy. Additionally, the patient would continue on one to one with security present and hand mitts would be added related to the patient's self-harming behaviors.
      A physician order dated 5/17/19 directed to apply bilateral hand mitts.
      Nurse's notes dated 5/17/19 at 3:53 PM identified mitts were placed on bilateral hands for safety due to unsuccessful education regarding patient's impulse to harm self, continue with two to one observation.
      Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that when she was made aware of why the patient was being admitted on 5/16/19 she immediately implemented interventions to keep the patient safe (one to one plus security, remote control to be kept out of the patient's room, no small objects in room). The Nurse Manager stated that the patient was placed on a one to one plus a security person,

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

items removed from the patient's room and when the patient was admitted to the unit all staff that were on at that time were educated, and staff after that were educated from the nurses.

Interview with MD # 1 on 7/1/19 at 2:25 PM stated that she went to see the patient on 5/17/19 after the nurse reported the patient was having pain and the patient reported that he/she inserted a needle cap into the urethra that was left behind from the nurse. MD # 1 stated that the patient reported to her that he/she inserted it the evening before but was not specific on the time.

Interview with Nurse Tech # 1 on 7/2/19 at 8:30 AM stated that on 5/17/19 at the change of shift the patient reported to the oncoming nurse that the evening before (5/16/19) around 9:00 or 10:00 PM he/she inserted a needle cap into the urethra.

Interview with Nurse Tech # 2 on 7/2/19 at 8:47 AM stated that on 5/17/19 the patient told the incoming day nurse that he/she inserted a needle cap into the urethra while in the bathroom. Nurse Tech # 2 stated that during his sit time (observing the patient), the patient remained in bed and did not use the bathroom.

Interview with Security Officer # 1 on 7/2/19 at 9:00 AM stated that when he was observing the patient (5/17/19 nights), the patient's hands were on top of the blankets. Security Officer # 1 stated that he was told by his supervisor to be facing the patient and constantly looking at the face and hands. Security Officer #1 stated that he was not present when the patient told staff he/she inserted a needle cap into the urethra but did hear the patient complain of pain. Security Officer #1 stated that he did observe some of the staff watching the patient and the television.

Interview with RN #1 on 7/2/19 at 2:00 PM stated that she went to see the patient on 5/17/19 (day shift) and was told by the patient that he/she "did it again". RN # 1 stated that she was told by the patient that he/she inserted a needle cap into the urethra the previous night around 9:00 PM. RN # 1 stated she notified the MD and the patient was sent to the OR to have the cap removed. RN # 1 further stated that the patient's room was cleaned and checked for any small objects and when the patient came back onto the unit mitts were placed on the patient's hands and staff was re-educated.

Interview with RN # 2 on 7/2/19 at 2:20 PM stated that during her shift (7:00 PM- 5/16/19 to 7:00 AM- 5/17/19) the patient complained of pain while urinating and she medicated the patient for pain. RN # 2 stated that she did not assess the patient's genital area when he/she complained of pain.

Interview with Nursing Tech # 3 on 7/2/19 at 2:35 PM stated that she was doing the one to one when the patient came from the Post Anesthesia Care Unit (PACU) on 5/16/19. Nursing Tech # 3 stated that she took the patient to the bathroom and he/she complained of pain when urinating. Nursing Tech # 3 stated she stood in the doorway and was going back and forth looking at the patient and around the room. Nursing Tech # 3 stated that at no time did she see the patient touching the genital area.

The hospital failed to ensure that a patient was adequately supervised by staff members resulting in the patient obtaining a needle cap and inserting it into the urethra which required a medical procedure to remove the cap.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

ii. Review of Patient #1's treatment plan dated 5/17/19 identified the plan was updated to include bilateral hand mitts.

Review of the patient safety checks documentation dated 5/19/19 at 12:45 PM identified the patient "ate a battery."

Physician progress notes dated 5/19/19 at 1:13 PM identified the patient complained of burning in the chest and had swallowed a battery in the morning. The note identified the patient was able to get his/her fingers out of the mitt and remove the battery from the television remote control and put it into his/her mouth. The note further identified the patient was to have an endoscopy to remove the battery and was now to have the hand mitts tied to prevent the patient from ingesting foreign objects.

Nurse's notes dated 5/19/19 at 6:54 PM identified that the patient remained on one to one supervision with security staff present. Patient #1 reported that he/she was able to remove 2 fingers from the hand mitt, remove the AA battery from the remote control and ingested the battery. The note identified the patient reported a burning sensation in the stomach, the physician was made aware and ordered a STAT X-ray which noted a battery in the patient's stomach. Review of the operative report dated 5/19/19 identified the patient underwent a endoscopy for the removal of a AA battery from the patients stomach. The note further identified that the patient's hand mitts were now to be tied, and every 2 hour room checks were to be conducted.

Review of the treatment plan dated 5/19/19 identified the treatment plan was updated to include tied bilateral hand mitts and room checks.

Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that the patient's treatment plan was updated after the patient ingested a battery to include tied bilateral hand mitts and room/bed checks every two hours.

Interview with MD # 1 on 7/1/19 at 2:25 PM stated that on 5/19/19 she went to see the patient after the patient complained of stomach burning and the patient told her that when the security staff put the remote down when security was changing staff, he/she removed the battery and then swallowed it. MD # 1 further stated that she spoke with nursing staff related to the two to one (one staff and one security) not working. MD # 1 stated that she had walked into the room at different times and observed the staff watching television and not watching the patient.

Interview with the Regional Manager of Security on 7/2/19 at 10:15 AM stated that he met with the nursing manager regarding the safety of the patient and educated his security staff regarding doing the sit (observation) on Patient # 1. The Regional Manager stated that after the second incident he came in again and re-educated the staff again on the sit and the new interventions the nursing staff implemented including tied hand mitts and every two hour room checks.

Interview with RN # 3 on 7/2/19 at 2:50 PM stated that she was called to the patient's room on 5/19/19 and the patient told her that he/she was able to remove 2 fingers out of the mitt and take the battery from the remote control, "fake coughed" and swallow a AA battery. RN # 3 stated that she could not recall if she asked the patient how or when he/she did it.

Interview with Security Officer # 2 on 7/2/19 at 2:30 PM stated that he was sitting

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

with the patient on 5/19/19 when the patient reported he/she swallowed a battery. Security officer # 2 stated that he was not sure where the remote was and that he was not responsible for it.
Interview with the Nurse Manager on 7/1/19 at 10:00 AM stated that the remote control to the television was to be kept outside of the patients room and that staff were educated on this when the patient was admitted.
The hospital's Observation of Patients policy identified that one to one observation is direct observation of a patient by a staff member.
The hospital failed to ensure that a patient was adequately supervised by staff members resulting in the patient obtaining an AA battery and ingest the battery, which required a medical procedure to remove the battery.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (e) Nursing Service (1) and/or (i) General (6).

2. Based on clinical record review, hospital policy and staff interview for 1 of 3 sampled patients reviewed for restraints, (Patient # 10) the facility failed to assess and document the use of a restraint every two hours according to hospital policy. The findings include:
   a. Patient # 10 was admitted to the hospital on 6/24/19 for self-injurious behaviors. Diagnoses included Schizophrenia.
   Physician orders dated 6/24/19 at 11:36 AM directed the use of bilateral soft hand mitts, tied (in accordance with the hospital policy for the non-violent non-self destructive patient).
   Review of the restraint assessment flowsheets dated 6/24/19 during the period of 11:36 AM through 3:45 PM failed to identify the patient was assessed every two hours, and failed to identify a physician order was written for the discontinuation of the tied bilateral hands mitts in accordance with hospital policy.
   Interview with Quality and Regulatory staff on 7/3/19 at 11:00 AM and review of the clinical record identified that Patient #10's restraint assessment flowsheet dated 6/24/19 failed to identify that the patient was reassessed for the use of the restraints every two hours as the restraint policy indicated. Quality and regulatory staff stated that it is the hospital policy to assess the patient's behaviors every two hours to ensure the restraints are needed.
   Review of the Restraint and Seclusion policy identified that patients using non-violent or non-self-destructive restraints are to be assessed every two hours. The assessment is to include the application of the restraint, signs of injury, physical and psychological status, patient care needs, range of motion, and need for least restrictive and/or discontinuation of restraints.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2)(B) and/or (1) and/or (i) General (6).

3. Based on clinical record review, hospital documentation and policy review, for 1 of 3 sampled patients reviewed for restraints (Patient # 1) the facility failed to ensure that the patient was examined by a provider when a daily restraint order was renewed. The findings include:
   a. Patient # 1 was admitted to the hospital 5/16/19 after inserting a foreign object into the

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

urethra.
Review of the clinical record identified the patient was placed in tied bilateral hand mitts on 5/19/19 at 1:00 PM until 5/20/19 at 1:30 PM.
Review of physician orders dated 5/19/19 at 1:04 PM directed to apply non-violent or non-self-destructive padded mitts, tied.
Physician orders dated 5/20/19 at 9:03 AM directed to apply tied bilateral hand mitts.
Review of clinical record with Quality and Regulatory staff on 7/3/19 at 11:00 AM failed to identify that the physician examined the patient on 5/20/19.
Review of facility policy for restraint and seclusion identified for non-violent or non-self-destructive restraints, the provider must examine the patient daily and enter a new order if restraints are to be continued.